Deaths in detention

Deborah Coles and **Helen Shaw** criticise the government for a lack of will to engage with the systemic failures highlighted by tragic deaths in detention settings.

> 'When I calmed down I asked them why they hit me in the nose and jumped on me. They said it was because I wouldn't go in my room so I said what gives them the right to hit a 14 year old child in the nose and they said it was restraint.'

These poignant words were written by Adam Rickwood who was found hanging in his room at Hassockfield Secure Training Centre in August 2004 – at 14 he was the youngest child to die in custody. Hours before his death, he had been subject to restraint by four male officers including the use of a technique designed to inflict pain known as 'nose distraction' and which caused his nose to bleed for an hour. His death followed that of Gareth Myatt a mixed race 15 year old boy who was killed at Rainsbrook STC on 19 April 2004 during the application of physical restraint methods which continued despite Gareth complaining he could not breathe, that he was going to defecate, did defecate, and then vomited. He died from asphyxia and was the first child to die following the use of restraint.

What became clear from the inquests in 2007 was the complete failure of the Youth Justice Board to properly manage the circumstances in which physical restraint was used and the safety and appropriateness of the techniques used. INQUEST has worked closely with the families and their legal team to brief parliamentarians, other child rights and penal reform organisations and the Children's Commissioner on the human rights abuses these cases exposed resulting in widespread public, parliamentary, and media concern about the treatment of children in custody.

After the conclusion of the inquest into Gareth Myatt's death the Coroner, His Honour Judge Pollard made a report to Rt Hon Jack Straw MP, Secretary of State for Justice and Lord Chancellor, under Rule 43 (of the Coroners' Rules). Following extensive consultation with the family's lawyers, the report specified 34 preventative actions which range widely over the treatment of children, the use of restraint, monitoring, good practice, access for emergency vehicles, and inspection saying that it would be 'wholly unforgivable and a double tragedy' if there was any delay in learning from and acting upon the lessons of Gareth's death. This followed the scathing narrative verdict reached by the inquest jury which implicated failures by the Home Office/Ministry of Justice and Youth Justice Board in the death.

The government's abiding lack of will to engage with the serious and wide-ranging failures to emerge from the tragic deaths is reflected by unjustified and undemocratic amending of the Secure Training Centre Rules. This broadened the circumstances in which children can be forcibly restrained without parliamentary debate or consultation.

Instead, in July 2007, the government announced a joint review of the use of restraint in STCs, Young Offender Institutions and Local Authority Secure Children's Homes. This review is an inadequate response to the broader systemic issues these deaths raise about how we deal with children in trouble with the law. A proper legacy for these families and their children would be an independent, holistic enquiry in public of the juvenile justice system with the effective participation of families, children, and those working within the youth justice system. Such an enquiry could effect meaningful change by moving us towards a more humane and safer society – and by preventing future child deaths. We fervently believe that there can be fewer goals which are more important.

INQUEST has been calling for such an enquiry since the death of 16 year old Joseph Scholes in HMYOI Stoke Heath in 2002. He was a vulnerable boy with a history of self-harming behaviour who, despite the expressed concerns of professionals with whom he was engaged and clear warnings by himself, took his own life, by hanging, in his prison cell just nine days into his sentence.

At the time of writing, we learned of the death of a 15 year old boy found hanging in HMYOI Lancaster Farms. Why, despite the deaths of 30 children in detention since 1990, have successive governments resisted a public enquiry? The deaths raise issues that go beyond the prison walls and to the heart of society's collective responsibility for tolerating a system that responds to challenging children and young people with punishment and the infliction of pain to control behaviour.

What often goes unmentioned is the high price paid by bereaved families in remaining involved in the lengthy, complicated investigation and inquest process. The families have shown incredible courage, diligence, and persistence to ensure that the disturbing issues surrounding the deaths of Gareth and Adam came to light. Without their participation in the process, it is doubtful that these hidden practices within STCs would have been exposed to any proper scrutiny.

While these two deaths are deeply shocking because they involve children, INQUEST deals on a daily basis with some of the most horrendous consequences of detention in prison, in police custody or in psychiatric detention.

Last year, INQUEST published

Unlocking the Truth: Families' Experiences of Investigation of Deaths in Custody that documents some of the unseen consequences of deaths in detention – the impact of a death and its investigation on the family of the deceased and the lack of adequate mechanisms to ensure similar deaths are prevented. INQUEST has consistently worked alongside families to build up relationships of trust, respect, and compassion so that the families feel empowered and engaged, and feel they can cope with the intrusive and complex legal process in which they are involuntarily engaged. The strategy of persisting in trying to broaden scope of enquiry at inquests, supported by detailed knowledge of other cases and an experienced network of lawyers, has ensured that the details of many deaths in custody are made public.

Establishing the truth about deaths in custody sheds light on the way we treat some of the most vulnerable men, women, and children in society. It is important that we recognise, scrutinise, criticise, and argue for reform of the way the state deals with deaths in custody, as these processes are an indicator of the condition of its democracy.

Last year, of the 45 inquests that have concluded on INQUEST's cases, many after delays of years since the death, four have involved deaths in psychiatric detention, six police custody, and 35 deaths in prison. Many of these inquests have been unreported, not even deemed worthy of a couple of lines in the local media. But they reveal, again, shocking failures in the treatment of vulnerable detainees. Inquests into deaths in police custody have highlighted ongoing concerns about the poor treatment of people with mental health problems, drug and alcohol problems, and poor medical care.

Running through INQUEST's work are concerns about the lack of accountability and failure to learn lessons to prevent similar deaths by taking follow up action on inquest and investigation outcomes across custodial institutions. We worked with others to successfully achieve amendments to the Corporate Manslaughter and Homicide Act 2007 to ensure it would apply to deaths in detention. The government attempted to present the current mechanisms of investigation and accountability as sufficiently robust. Parliament disagreed, and this was further underlined when the Forum on Deaths in Custody published its Annual Report in September 2007 in which the number of deaths in all forms of custody in the preceding year were officially collated and published centrally for the first time. These figures need more scrutiny and analysis than the Forum can provide, in particular the 328 deaths in psychiatric detention.

It does not have the capacity to research deaths in custody, to collate and analyse jury findings and coroner's reports or to monitor the implementation of recommendations arising from inquests or investigation reports. It cannot call to account and recommend action against those institutions and individuals who fail to take action. In May 2007, the government conceded that the Forum's powers and resources were insufficient and made a commitment to reviewing and strengthening the current arrangements, something which is ongoing.

INQUEST has proposed a properly resourced independent overarching Standing Commission on Custodial Deaths with statutory powers to address the complexity and breadth of issues that arise. It is clear that the current mechanisms are insufficient as death after death occurs revealing horrific conditions and lack of basic humanity in the care of detainees. In November 2007, the inquest into the death of 25 year old Martin Green, who died in HMP Blakenhurst in July 2002, concluded with the jury returning a highly critical narrative verdict. Found dead in his cell in the health care centre while undergoing detoxification, Martin, who was 188 cm (6 ft 2 in) tall, weighed just 43 kg (6 st 10 lbs). The jury made numerous criticisms in their verdict, and concluded that his poor medical state coupled with poor assessment, planning, and communication contributed significantly to his death.

The shocking fact of this case, the lack of media interest in the inquest, and the delay of nearly five years in concluding the investigation make a mockery of the government's arguments earlier last year that current investigation mechanisms are sufficient, further illustrated by the last-minute ditching of the promised coroners reform bill. The circumstances of this death raise very serious questions about the quality of medical care afforded prisoners in the custody and care of the state. Martin Green was owed a particular duty of care, and that duty was not met. As a result, he died an inhuman and degrading death.

The number of custodial deaths remains far too high, and many cases reveal a horrendous catalogue of failings in the treatment and care of vulnerable people in custody or otherwise dependent on others for their care. They raise questions about excessive and inappropriate use of custody for some of the most vulnerable people in society; they also highlight failures to fulfil the state's duty to protect life. Inquests repeatedly identify the failure to implement existing guidelines on the care of 'at risk' detainees.

It is clear from INQUEST's monitoring and analysis of deaths in custody that understanding why these deaths occur requires an examination of their broader social and political context. No discussion of self-inflicted deaths in prison can ignore the regimes and conditions operating in prisons, criminal justice policies that imprison the mentally ill and vulnerable or the institutional culture of violence and racism that exists there. ■

Deborah Coles and **Helen Shaw** are co-directors of INQUEST.
http://www.inquest.org.uk

10.1080/09627250801937652